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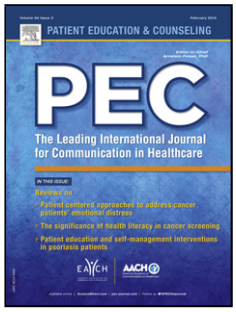

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Interaction—a missing piece of the jigsaw in interpreter-mediated medical consultation models

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Highlights

- Guidelines for working with interpreters provide a quick and convenient toolkit.
- The oversight of co-construction in communication is limiting their usefulness.
- Interdisciplinary social and clinical research is required to advance knowledge.
- Sustainable and effective stakeholder network are needed to foster collaboration.
- Acknowledging professional interpreters as part of the healthcare team is key.

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Abstract:

In 2015, at the International Conference on Communication in Healthcare in New Orleans, USA, we formed a symposium panel to discuss and debate how interdisciplinary research can inform interpreter-mediated medical consultation training. In all our work, a recurring theme is not just the strengths but also the shortcomings of the guidelines proposed in the textbooks and widely used in medical education. This paper is an account of our multidisciplinary reflections on a prominent issue of the lack of attention to *interaction* in communications, which shed light on the limitations of these guidelines and clinical communication models. We propose that an international network be established for all stakeholders to foster interprofessional and interdisciplinary collaboration for research and clinical interventions, and to inform training and policy making.

Keywords: Interpreter-mediated consultation; Interaction, Communication guidelines; Interprofessional

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In 2015, 244 million people, that is, 3.3% of the world's population lived outside their country of origin [1]. The more developed world hosted '60% of all the immigrations or foreign-born persons' [2], most of whom migrated for better economic and social opportunities [1] . The recent migrant crisis in Europe brings the language and cultural discordances to the fore, drawing clinical practitioners and educators' attention to health disparities and equality in healthcare in Europe. Various methods have been implemented, including the use of interpreters in clinical encounters **where interpreters are expected to act in an uninvolved and machine-like manner between doctors and patients. This conduit role of the interpreter means that they are expected to decode the patient's and doctor's message from one language, encode it in another language and pass it on to each other in the most neutral, uninvolved and almost invisible manner possible. This representation of the interpreter is outdated, as research has shown that interpreters are fully-fledged participants who do not transmit messages in a vacuum but interact with the speaker and the listener as active participants in communication [1,3]. This outdated representation of the interpreter is currently being perpetuated in textbooks and guidelines on interpreter-mediated communication in healthcare.**

We are a group of international researchers and educationists who use these textbooks and publish on the subject. In 2015, we formed a panel to give a symposium on Using Interdisciplinary Research to Inform Interpreter-mediated Consultation Training at the International Conference on Communication in Healthcare in New Orleans, USA. A recurring theme in all our work is the shortcomings of several guidelines proposed in the textbooks and widely used in medical education. While these guidelines seem to provide immediate

guidance, they are very limited, especially under the predominant frame of patient-centred healthcare.

Most of the existing guidelines provide guidance on administration for accessing interpreting services, highlighting the extra procedures the healthcare professional should undertake in a consultation and prescribing simple behavioural adaptations to facilitate communication. Their immediate effect highlights the extended structure of a mediated consultation, such as briefing and debriefing the interpreter before and after the consultation, checking that the interpreter speaks the same language and dialect as the patient, double-booking for interpreter-mediated sessions etc. Implementing these practical procedures increases the chance of ensuring that an appropriate interpreter will be arranged and supported by the clinicians. In our teaching, we find these models a useful addition to existing communication training. We notice that the checklist points are easy to teach. Trainees can quickly translate them into clinical practice, and those who have limited experience working with interpreters can be encouraged to practise, even though they may find it daunting at first. In addition, we find that clinical examiners, who are familiar with the format of OSCE mark sheets, for instance, find the models' checklist format easy to use in exams. The simplicity of the guidelines, however, is also where the problem lies.

Most of us adopt an interactional approach to research language and communication in clinical contexts. We see medical consultations as a dynamic interactive process, during which the doctor and patient co-construct and negotiate the meanings and means of talk. In any face-to-face conversation, participants try to establish the mutual belief that they have understood each other well enough for current purposes. This process of building a shared understanding, or *intersubjectivity*, is accomplished through interaction. This view suits the patient-centredness parameter, and has been slowly adopted by mainstream clinical

communication education [4] but, as we will outline below, it is not sufficiently reflected in guidelines for interpreter-mediated consultations.

Achieving sufficient intersubjectivity is arguably central to the process of interpretation. In order for the interpreter to function, he or she must work moment by moment to understand the primary participants' meanings well enough to construct the main ideas behind what was said into the other language. In basic research on how interactants understand each other, the *social* processes of interacting in conversation are recognized as playing a central role in the *cognitive* processes of understanding [5]. These authors cite experimental evidence demonstrating that listeners who actually participated in a conversational interaction go about achieving understanding very differently from those who can only overhear the conversation, so much so that overhearers (i.e., those who are excluded from interacting) achieve low levels of understanding.

Several guidelines for working with interpreters relegate the interpreter to being a side-participant (e.g., the doctor should look at the patient, not the interpreter, or the interpreter should ask primary participants to address each other directly). These guidelines risk confining the interpreter to the role of an overhearer, present but completely excluded from interacting. Thus in these guidelines, the 'conduit' role of an interpreter prevails.

The assumption of the interpreter's conduit role also challenges the established notion of the relationship between language and meaning. Oquendo notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation; that is, meanings may be coded, emotionally processed and internalised in one language and may not always be directly accessible in another [6]. To accomplish the challenging task of translation, interpreters need to resort from their linguistic and cultural knowledge to their

best knowledge in order to accurately judge the ongoing interaction and the intended meanings embedded in it.

The guidelines also advise on visible aspects of communication, including gesture and gaze. Advice that the doctor should maintain direct eye contact with the patient (and not look at the interpreter) further removes the interpreter from the interaction. In naturally-occurring conversation, interlocutors watch each other, both to view each other's integrated messages (including both speech and visible action) and to assess (albeit implicitly) whether they have understood each other well enough to proceed further. Under the strict use of these guidelines, doctors, interpreters and patients could not freely observe each other closely. While such guidelines are helpful in terms of offering suggestions for ways to pre-empt problems in understanding (speak slowly and clearly, keep it simple), they deter attempts to assess whether those efforts have achieved understanding. Communication training that does not develop the trainees' sophisticated skills to manage the dynamic interaction makes communication extremely vulnerable to creating, and exacerbating, misunderstandings.

An interactive approach to mediated consultations is the opposite of the 'conduit' model of interpreting. It acknowledges the active role of the interpreter, as any other participant, who co-constructs the meanings and means of the conversation. This is a sophisticated process requiring continuous negotiations among all participants, which includes negotiating the words and their meaning that are being expressed, as well as the ways in which they are expressed. Guidelines, therefore, should not be reduced to behavioural suggestions, such as keeping eye contact or using 'you' to refer to the patient instead of 's/he'. Heuristic as they may be, they do not help doctors to navigate the complicated negotiations in the interaction. Instead, guidelines that do pay due attention to interaction and acknowledge the active role of the interpreter will be more likely to change

practitioners' attitudes toward interpreter-mediated consultations. In this way, practitioners will be more likely to assess the changing situations of the ongoing interaction critically and, as such, to adapt their interactive behaviour effectively ("immediate endpoints" [7]) such as, for instance, gaze, in order to meet their goals (e.g. building a relationship) during their communication. For instance, guidelines may include a recommendation addressed to practitioners not to focus their gaze on the patient alone, but to use it as a means of achieving their goals both with their patient and the interpreter according to the ongoing interaction. Yet, in order to ascertain whether, to what extent and under what circumstances an adaptation of the doctor's interactive behaviour in the light of the interpreter's role as active participant would serve their goals both toward the patient and the interpreter requires further research.

Conclusion

Interaction is the missing piece of the jigsaw in current understanding of interpreter-mediated consultations portrayed in communication models and training guidelines. To reinstate it requires much more work than a change of perception of interpreters and prescribed communicative behaviours. We would, therefore, like to make three suggestions for moving forward in addressing the challenges in discussion. Firstly, given the still limited empirical research in interpreter-mediated clinical communication, more interdisciplinary research is required to bring together expertise, including medical sociology, linguistics, interpreting studies and educationists, to advance knowledge about cultural and linguistic diversity and to address challenges along the way. Past experience suggests that research outcomes are not always translated into clinical practice. Therefore, the second proposal we make is to build a sustainable and effective network across the stakeholders at all levels to

allow research to draw on required expertise in addressing the challenges to provide optimal patient care, and to allow research outcomes to be translated into training and practice. Thirdly, we strongly suggest that professional interpreters become part of the interprofessional healthcare team to allow healthcare professionals and medical interpreters to learn with, from and about, each other. Effective teamwork between the two groups of professionals will result in better care for vulnerable patients of different cultural and linguistic backgrounds. The authors have established a Special Interest Group (SIG) on Language and Cultural Discordances in Healthcare Communication under International Association for Communication in Healthcare. The SIG aims to build an international network for all stakeholders, to foster interprofessional and interdisciplinary collaboration for research and clinical interventions, and to inform training and policy-making. Interaction seems to be one problem that relates to all. Language and cultural discordances in healthcare communication are complicated and constantly evolving. We hope this international initiative will go some way towards addressing health discrepancy and achieving better and equitable care for all in today's diverse society.

Conflict of interest

All the authors declare that there is no potential conflict of interest.

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